



OFFICE AND FINANCIAL POLICY

1. Payment Due. Self-pay accounts are due at the time of service unless other arrangements are made. Co-pays are due at the time of service. If any check is dishonored and returned unpaid, you will be charged \$25.00.
2. Financial Responsibility and Insurance. You are financially responsible for all charges whether covered by insurance or not. Insurance information must be provided prior to receiving services and must be updated upon any change. We agree to use this information to bill your insurance company and to apply payments to your account. Your insurance may require a referral or prior authorization. If this is not provided you may be asked to reschedule your appointment, pay for your visit at the time seen and/or sign a waiver. If we are not a contracted provider for your insurance, and you still want to be seen in our office, you will be asked to pay at the time seen and sign a waiver. If you are the parent or guardian accompanying the patient, you assume the liability. This office will not be involved in mediating financial arrangements between parents or guardians and are not a party in any divorce decree.
3. Past Due. Any account that does not receive monthly payments, for more than 60 days, will be treated as delinquent or "past due" and collection procedures will start. Any account that remains unpaid for 90 days, or does not receive monthly payments, may be sent to a collection agency and may result in patient dismissal.
4. Collection. Past due accounts may be assigned to a collection agency or attorney for collection. In the event that legal action is taken to collect any amounts owed, the prevailing party shall be entitled to recover their reasonable attorney fees.
5. Missed Appointment Fee. Patients who do not cancel, and miss their appointment, may be charged \$25. This fee must be paid before patient can be seen again.
6. Outside Fees. Patient who have a biopsy or surgical procedure may receive a separate bill from an outside laboratory for pathology services in addition to the ones we charge. This happens if a consultation/second opinion is requested by your dermatology provider.
7. Credit Balances. Credit balances under \$10 and less than one year old, created by patient payment, will not be refunded unless requested by the patient.
8. Patient Dismissal. We reserve the right to dismiss a patient for disrespectful or threatening behavior towards staff or for non-payment of account. If such action must be taken you will be informed by mail.
9. Communication Consent. You agree, in order for us to remind of appointments, service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account. We may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Your consent to these communications applies to those initiated by our office, or by any agent, attorney or collection agency acting on our behalf.

By my signature below, I acknowledge that I have read and understand the foregoing Office and Financial Policies and agree to its terms. I authorize the release of all medical information necessary to process claims and I assign any insurance benefits or proceeds to David F. Young, M.D.P.C. I authorize the release of medical information to my primary care physician for coordination of care.

Signature (Patient or parent/guardian)

Date